Commonwealth of Kentucky
Cabinet for Health and Family Services (CHFS)
Office of Health Policy (OHP)

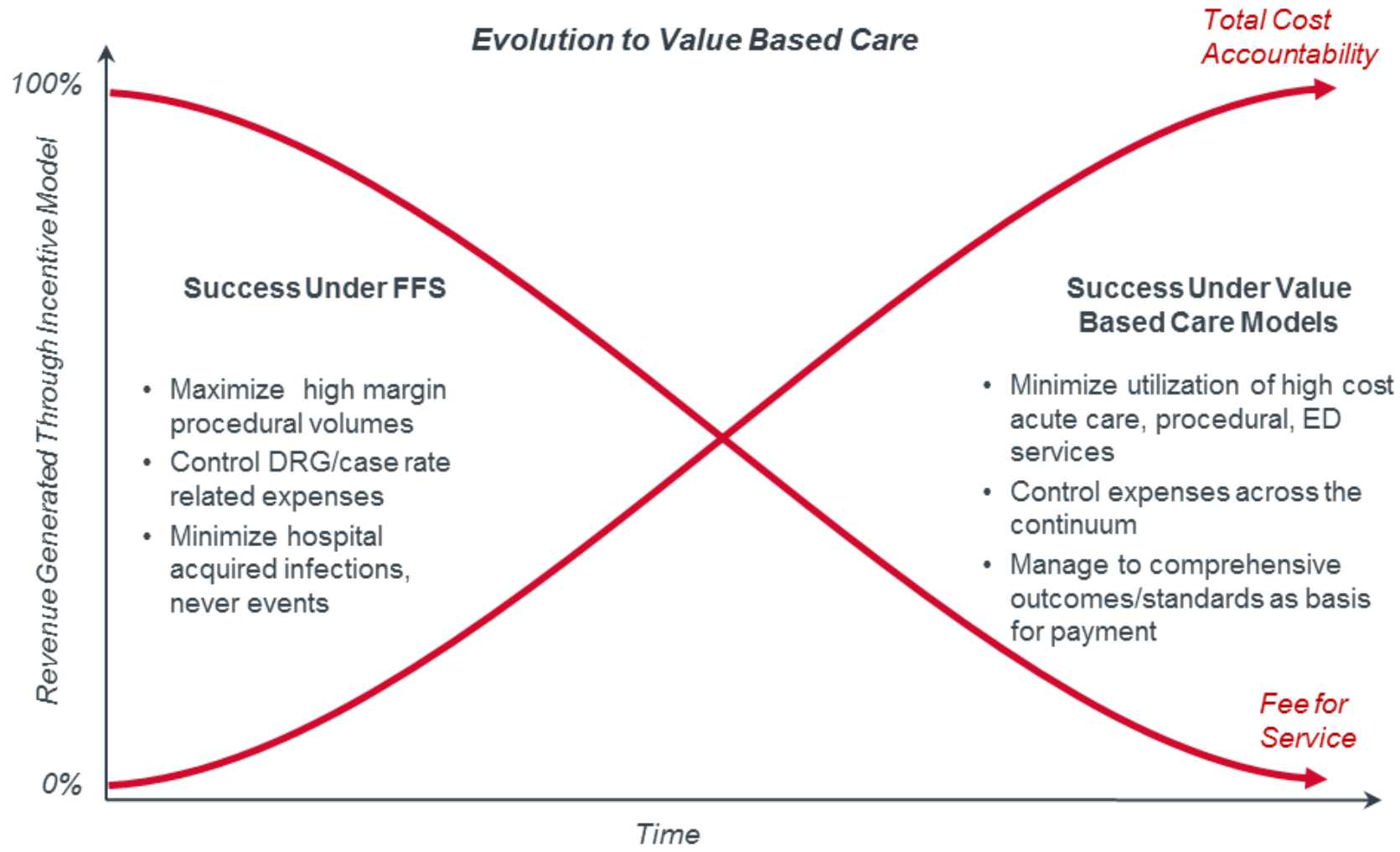

*State Innovation Model (SIM) Model Design*
*Navigating the Needs of Rural and Small Hospitals*
*May 15, 2015*

# Meeting Agenda

| | |
|---|---|
| 8:30 – 9am | **Registration and Light Breakfast** |
| 9 – 9:15am | **Welcome & Introductions**<br>*Audrey Tayse Haynes, Secretary, Cabinet for Health and Family Services* |
| 9:15 am – 11:45am | **Presentation & Facilitated Discussion**<br>*Ken Keller, Vice President, The Advisory Board Company*<br>• Overview of SIM Model Design Project & Relevant Health Industry Changes – *Ken Keller*<br>• Challenges and Opportunities for Rural Hospitals in an Era of Health System Transformation – *Open Discussion*<br>• Adapting Successfully in a Time of Change - Strategies and Models for Success – *Ken Keller*<br>• Question & Answer Session |
| 11:45 am – 12pm | **Closing: Next Steps in the SIM Process; Rural Hospitals as Key Partners in the Process**<br>*Emily Whelan Parento, Executive Director, Office of Health Policy* |

# The Common Fundamental Challenge Facing Providers Today

## Shifting Paradigm Requires Navigating Two Disparate Models



# Pressure from Payers not the Only Provider Challenge

## Financial, Clinical Trends Shifting Dramatically

### Decelerating Price Growth

- Federal, state budget pressures constraining public payer price growth
- Payments subject to quality, cost-based risks
- Commercial cost-shifting stretched to the limit

### Continuing Cost Pressure

- No sign of slower cost growth ahead
- Drivers of new cost growth largely non-accretive

### Shifting Payer Mix

- Baby Boomers entering Medicare rolls
- Coverage expansion likely boosting Medicaid eligibility
- Disproportionate growth in demand for services from publicly insured patients

### Deteriorating Case Mix

- Growing medical demand from aging population threatens to crowd out capacity for more acute therapies
- Rising incidence of chronic disease and multiple comorbidities

# Health Reform Continues Full Steam Ahead

Affordable Care Act Remains (Mostly) Intact After Legal, Political Challenges

**Major Milestones of ACA Rollout**

*2012–2018*

2012
**Rise of Accountable Payment Models**

- Medicare Advantage bonuses
- Hospital Value-Based Purchasing Program
- Medicare Shared Savings Programs
- Hospital Readmission Reduction Program
- Center for Medicare and Medicaid Innovation (CMMI)

2013
**Implementation of New Financing Mechanisms**

- Medicare tax increase
- Excise tax on medical devices
- Disproportionate Share Hospital (DSH) payment reductions

2014
**Launch of Coverage Expansion**

- Guaranteed issue
- Community rating
- Health insurance exchanges
- Individual, employer mandates
- Optional Medicaid expansion to 133% of the Federal Poverty Level (FPL)

2015-2018
**Elevated Penalties for Drivers of Excess Cost**

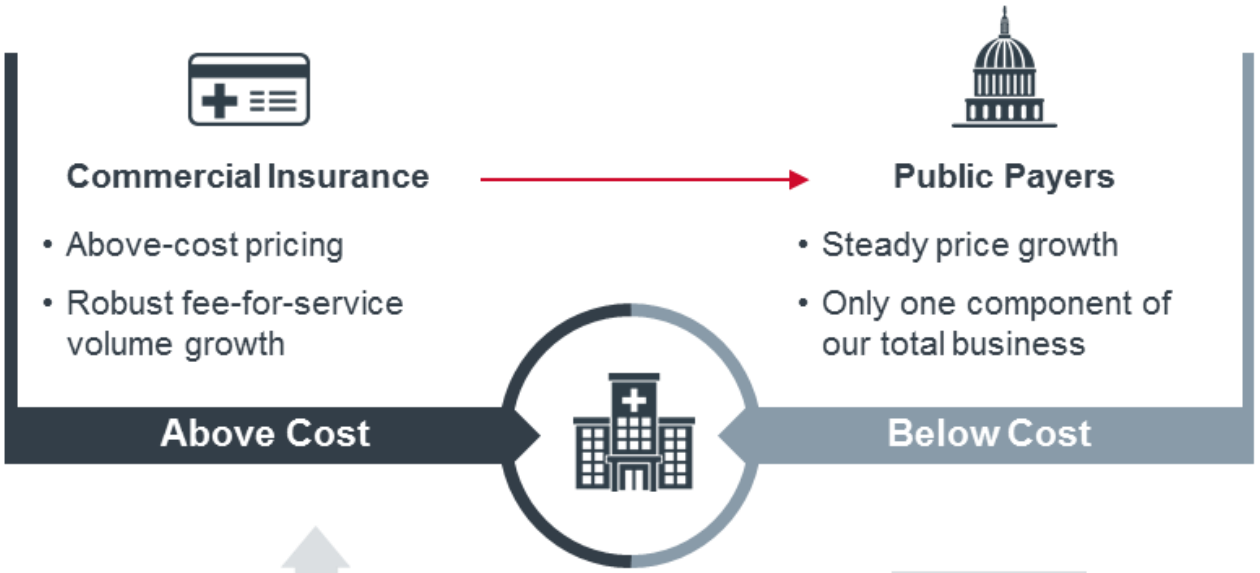
- Hospital-acquired condition penalties
- Independent Payment Advisory Board (IPAB) recommendations
- Individual, employer penalty increases
- Excise tax on “Cadillac” health plans

Source: Health Care Advisory Board interviews and analysis.

# Tenuous Financial Model of Hospitals at a Crossroads

## Most Hospitals Staying Afloat Through Cross-Subsidization

### Traditional Hospital Cross-Subsidy



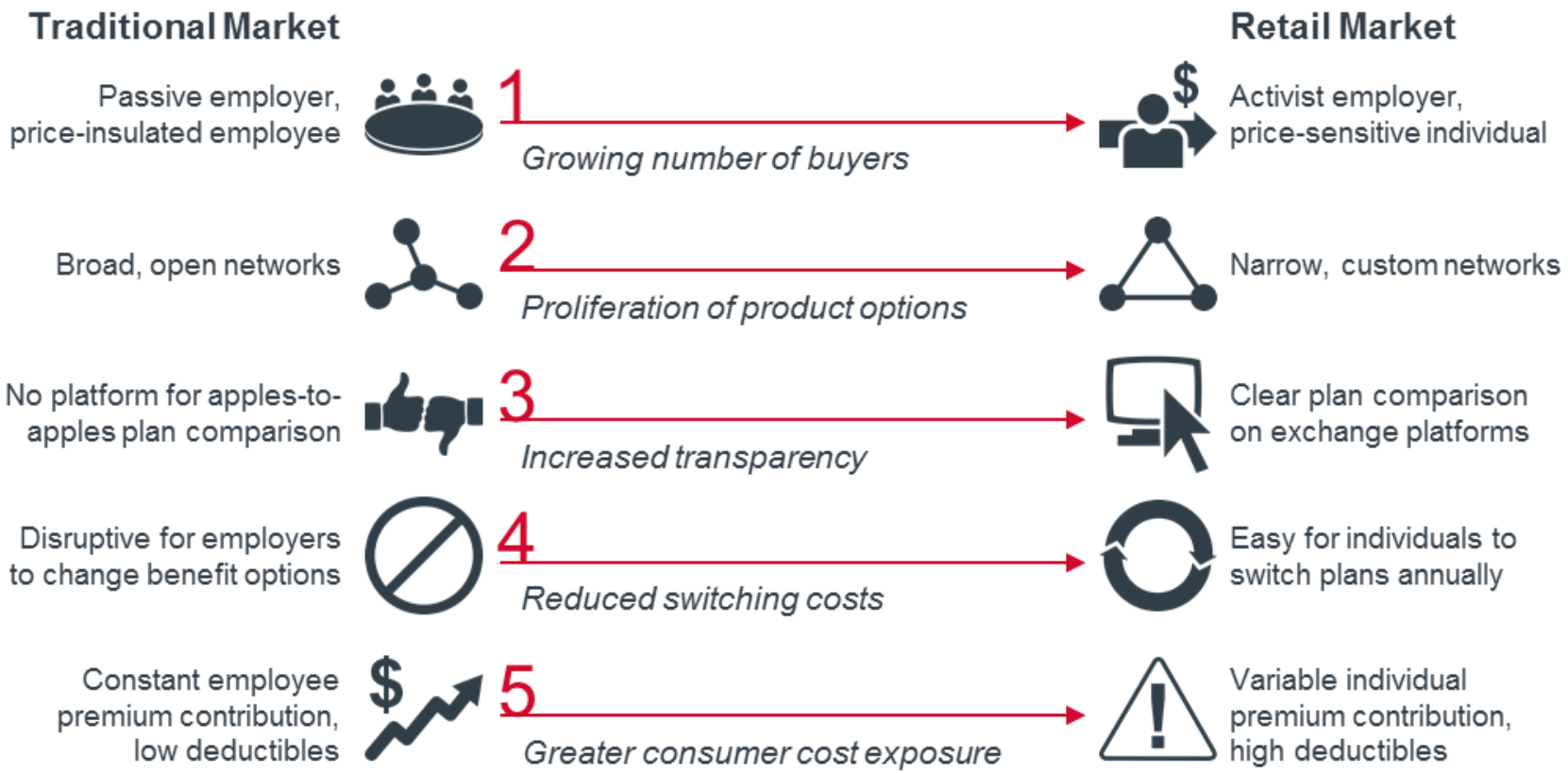

**149%**
Hospital Payment-to-Cost Ratio, Private Payer, 2012

**86%**
Hospital Payment-to-Cost Ratio, Medicare, 2012

Source: American Hospital Association, "Trendwatch Chartbook 2014," available at: www.aha.org; Advisory Board interviews and analysis.

# The Market Forces Pushing Ahead Independent of the ACA

## New Dynamics Unfamiliar in Health Care, But Not in Broader Economy




Source: Advisory Board interviews and analysis.

# Overview of SIM Model Design

# CMS' Goals for the SIM Program

The Centers for Medicare & Medicaid Services (CMS) State Innovation Model (SIM) initiative is focused on testing the ability of state governments to use regulatory and policy levers to accelerate health transformation.

- CMS is providing financial and technical support to states for developing and testing state-led, multi-payer health care payment and service delivery models that will impact all residents of the participating states
- The overall goals of the SIM initiative are to:
  - *Establish public and private collaboration with multi-payer and multi-stakeholder engagement*
  - *Improve population health*
  - *Transform health care payment and delivery systems*
  - *Decrease total per capita health care spending*

| Current System | Future System |
|---|---|
| • Uncoordinated, fragmented delivery systems with highly variable quality<br>• Unsupportive of patients and physicians<br>• Unsustainable costs rising at twice the inflation rate | • Affordable<br>• Accessible to care and to information<br>• Seamless and coordinated<br>• High-quality – timely, equitable, and safe<br>• Person- and family-centered<br>• Supportive of clinicians in serving their patient's needs |

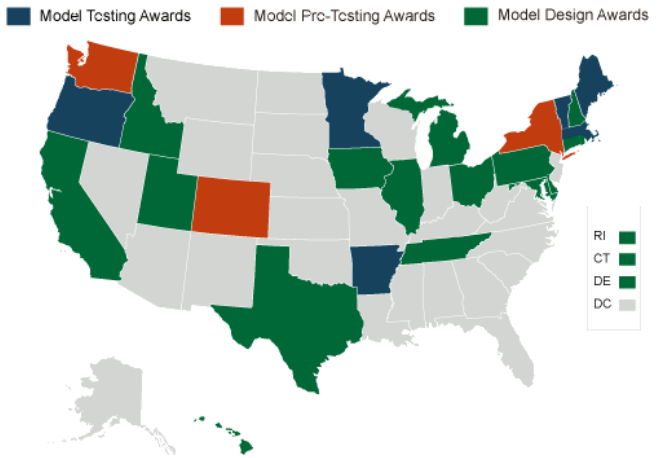
Source: CMS SIM Round Two Funding Opportunity Announcement Webinar

**CMS' Triple Aim Strategy**

**Improve health system performance** → **Increase quality of care** → **Decrease costs**

# Current Landscape of the SIM Program

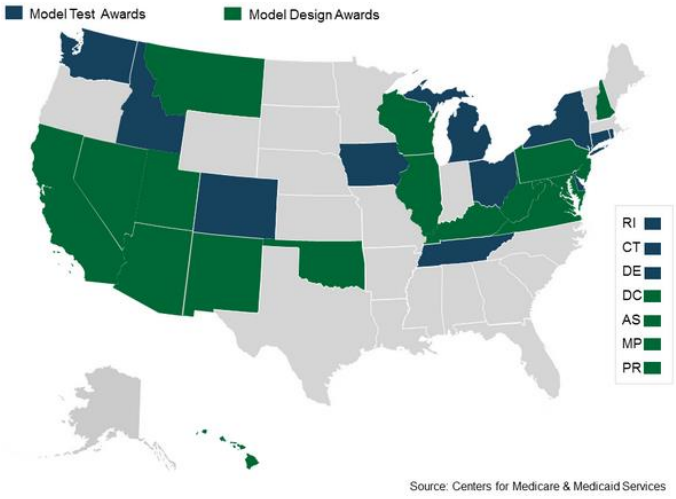
The Center for Medicare & Medicaid Innovation (CMMI) within CMS awarded states cooperative agreements in two rounds to design and implement strategies for service delivery and payment reform.




Source: Centers for Medicare & Medicaid Services

## Round 1 SIM Grant Recipients

- Nearly $300 million was awarded to 25 states in December 2012 to design or test innovative health care payment and service delivery models during Round 1 of the SIM initiative.
- Awardee Breakdown
  - **Model Testing Awards:** 6
  - **Model Pre-Testing Awards:** 3
  - **Model Design Awards:** 16



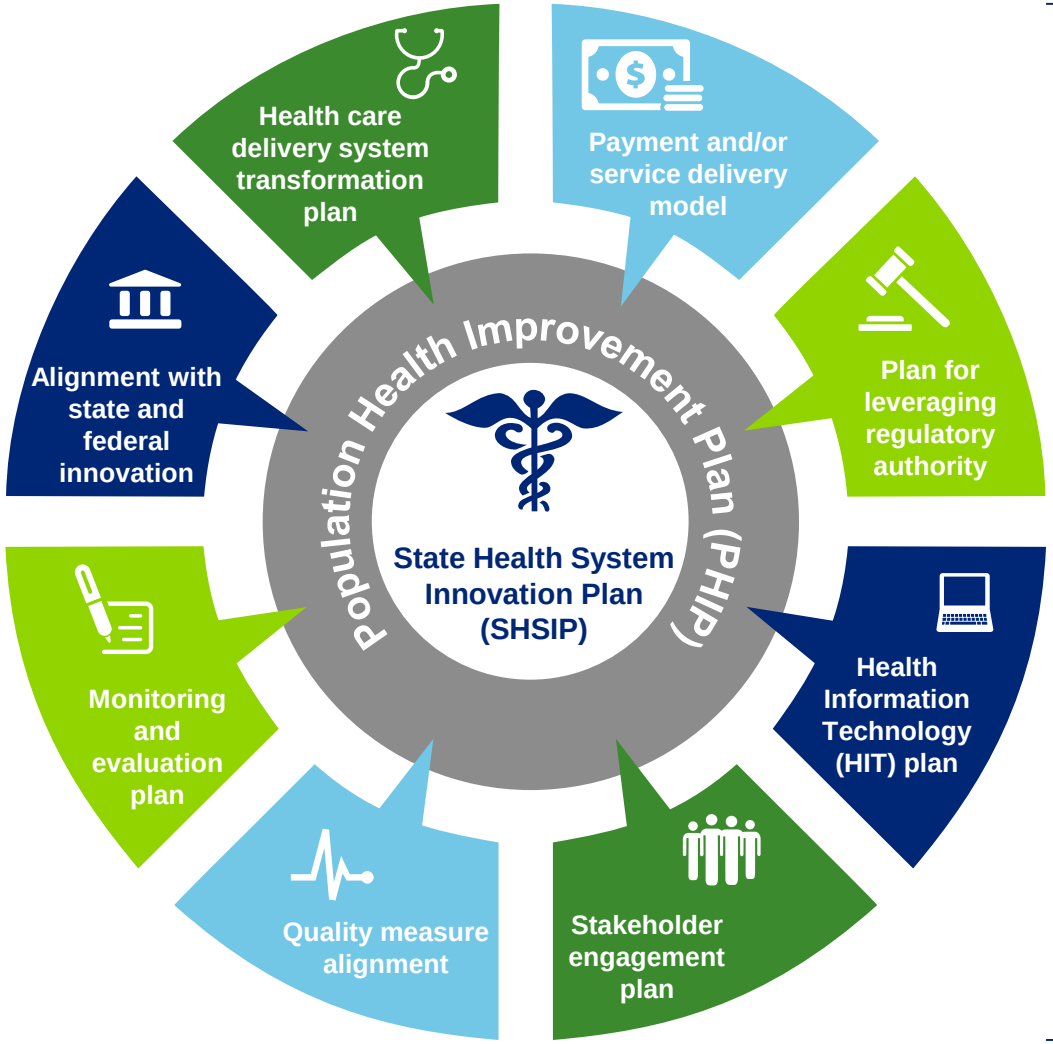

Source: Centers for Medicare & Medicaid Services

## Round 2 SIM Grant Recipients

- CMMI added more parameters in Round 2 that better correlate with successful statewide health transformation. It also selected Model Test/Model Design applications based on their potential to impact the health of the entire state population.
- In December 2014, more than $660 million was provided to 32 awardees (28 states, three territories, and the District of Columbia) for Round 2.
- Awardee Breakdown:
  - **Model Testing Awards:** 11
  - **Model Design Awards:** 21

# Components of a SIM Model Design

CMS requires a State Health System Innovation Plan – also referred to as the "Model Design" – as the final deliverable for a SIM Model Design grant.




**Components of a successful Model Design**

# Challenges and Opportunities for Rural and Small Hospitals

# Rural Providers Rely on Strong Collaborative Relationships

## Collaboration Can Trump Demographic Challenges and Resource Limitations

***Leverage Community Skills and Resources***


***Examples of Community Organizations for Potential Partnership***

- Public Health Departments
- Local Health Care Providers
- Local Businesses and Chambers of Commerce
- Community Organizations, such as Churches, Libraries, Schools
- Local and National Charities
- Health Care Payers
- Financial Institutions
- Local Media
- Urban Health Centers
- Other Government or Municipal Agencies (e.g. Police, Fire Dept.)

# Opportunities to Leverage for Population Health Management

## Strong Community and Patient Relationships

- Hospital is one of the largest employers in the community, which creates a stronger brand and perception
- Residents have a limited number of health care options, resulting in long-term relationships
- Working with urban health centers and larger health systems, rural hospitals can offset costs and gaps in resources

## Integration of Services

- Increased use of electronic tools and technology, including the use of telemedicine
- Partnering with other local health providers for care delivery (home health, prevention and post-acute care)

## Federal Financial Assistance

- Operating as critical access hospital (CAH) provides opportunity for additional funding
- Graduate medical education redistribution of unused residency slots gives priority to rural training tracks
- CMMI pilots and other project funding opportunities

# Putting Principles into Practice

## *Key Program Characteristics*

| 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|
| Selective, scaled membership | Physician-led care improvement efforts | Infrastructure for care coordination | Performance management system | Legal, meaningful incentives | Joint Payer contracts |

## *Golden CI Program*

| Patient Safety Training | Diabetic Collaboratives | Online Physician Portal | Physician Report Cards | P4P Bonus Payments | All Major Plans in Market |
|---|---|---|---|---|---|
|  |  |  |  |  |  |

### Case in Brief: Golden Medical Center[1]

- Small southeast region independent community hospital with approximately 100 beds
- Sponsored CI Program now includes nearly 75% of medical staff in community
- Multiple payer relationships across commercial and governmental programs
- Extensive collaboration between CI Program and hospital for quality and cost improvement initiatives

1) Pseudonym

Source: Health Care Advisory Board interviews and analysis.

# Results Attained and Delivered

*Relationships driving tangible results to physicians and hospital*

- Redesigned quality improvement efforts of facility; physicians now drive process improvement efforts across enterprise
- Reduced health plan increases for Golden Medical Center health plan participants by ~ 12% over three year period
- Benefit plan restructured to fully align participating physicians that redirected ~ $10 million in health care claims to program physicians over two year period
- Partnership enabled Golden Medical Center to improve efficiency by ~ $7 million in order to absorb 10% reimbursement cut by State for Medicaid beneficiaries
- Executed, maintained and grew agreements with local employers and commercial plans


# "Sustainable Growth Rate" (SGR) and Impact to Physicians

- Permanent repeal of the SGR will dramatically alter Medicare payments to physicians

- The "Medicare Access and CHIP Reauthorization Act of 2015" (MACRA) will significantly accelerate Medicare's shift toward value-based payments for physicians

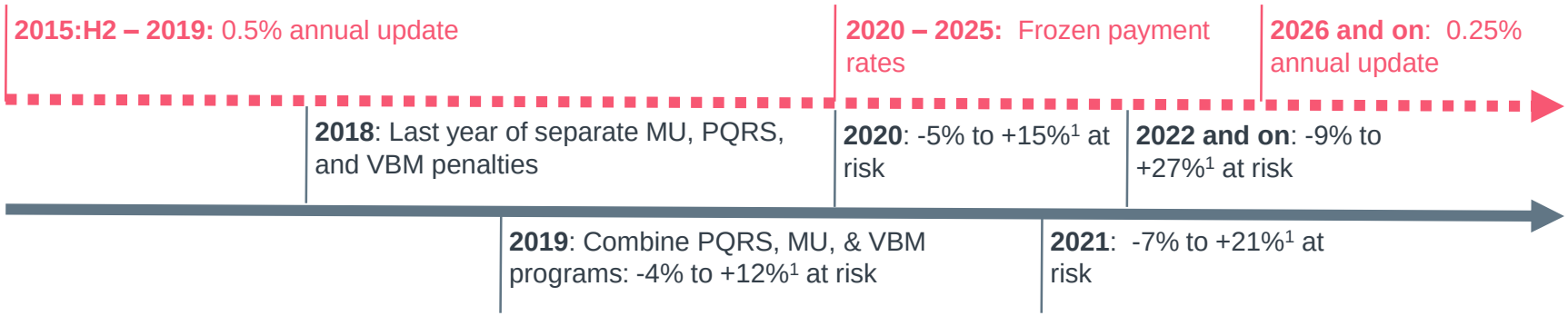
- MACRA introduces two value based payment "tracks" for physicians
  - **The Merit-Based Incentive Payment System -** MACRA consolidates and expands pay-for-performance incentives within the fee-for-service system, creating the new Merit-Based Incentive Payment System (MIPS). Under MIPS, the Physician Quality Reporting System (PQRS), EHR Incentive Program, and Physician Value-Based Modifier become part of a single payment adjustment to physician payments beginning in 2019.

  - **The Alternative Payment Models Track -** MACRA allows providers participating in "Alternative Payment Models" (APMs) to opt out of MIPS if providers meet increasing thresholds for the percentage of their revenue they receive through qualifying financial risk arrangements under the APMs.

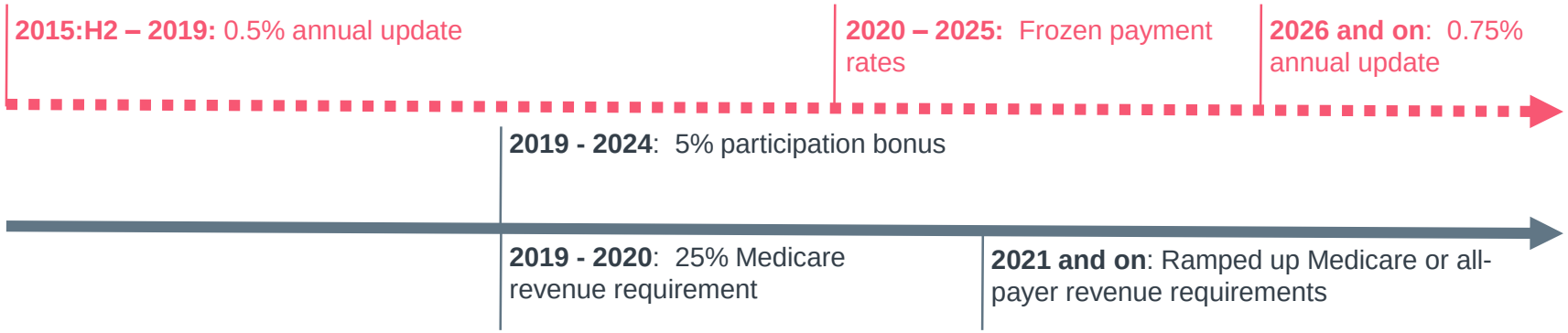
# … By Creation of Two Payment Tracks for Providers

Providers Must Choose Enhanced FFS[1] or Accountable Care Options

## Merit-Based Incentive Payment System




## Advanced Alternative Payment Models[2]




1. Fee for service.
2. Positive adjustments for professionals with scores above the benchmark may be scaled by a factor of up to 3 times the negative adjustment limit to ensure budget neutrality. In addition, top performers may earn additional adjustments of up to 10 percent.
3. APM participants who are close to but fall short of APM bonus requirements will not qualify for bonus but can report MIPS measures and receive incentives or can decline to participate in MIPS.

Source: *The Medicare Access and CHIP Reauthorization Act of 2015*; Advisory Board analysis.

# Adapting in A Time of Change

*Strategies and Models for Success*

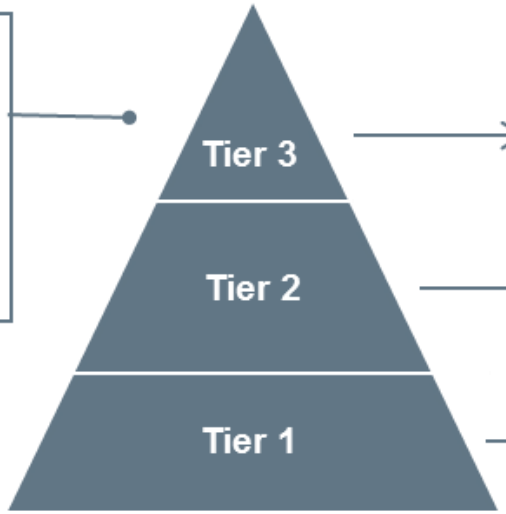
# Starting with the Hospital's own Employee Population

## Mason District Hospital's "Start in your own backyard" Approach

**Case in Brief: Mason District Hospital (MDH) Employee Wellness Initiative**

- 20-bed Critical Access Hospital serving over 18,000 people in the rural west-central region of Illinois
- 80% of health care dollars are used by 20% of benefit plan participants; the 5% with multiple chronic conditions spend half of the health care dollars each year
- All participants in the program receive a 15% reduction in premiums and complete preventative care to include risk-appropriate screenings; Required to complete one wellness activity every quarter
- After two years, the hospital reduced health care costs by **$45,000 per person, per year**

8 employees identified to have multiple chronic conditions and a care coordination plan was developed to provide one-on-one patient education, monitoring and outcome identification




Multiple chronic diseases
- Assigned to a Health Advocacy Team composed of an NP, RN and Psychologist or Social Worker; Required to meet regularly to develop and comply with consolidated care plan

No chronic diseases, but rising risk
- Required to participate in wellness activities or else penalized; Access to telephone health coach

No major health issues
- Required to participate in wellness activities throughout the year

# Build Wellness Promotion Model for Scalability

## Integrated Health Advocacy Program

### Build First for the Hospital...

Because rural areas often have a lack of health promoting amenities, MDH built a fitness center, hired a nutritionist and trainer, created a community garden and opened other facilities to the community for a small fee to maintain the other programs such as in as diet courses, cooking classes, fitness center memberships, etc.

**Isolated success within the Hospital**

Employees saw a reduction in premiums because they became healthier in terms of less or improved chronic disease conditions and fewer doctor or hospital visits

### ...and then Scale to the Community

This model was established to be scalable so that it could be implemented in self-insured community businesses using the wellness teams at MDH. The businesses pay to access the programs and services, which generates an additional revenue stream for the hospital

**Collective success within the Community**

# Adirondack Medical Home Pilot

**Case in Brief: Adirondack Health Institute**

- 5 Rural Counties in the Northeast region of New York State – One-fifth of land area in NY but less than 1% of the total population
- 5 Hospitals in the region totaling 545 beds
- Significantly older population and disproportionately poor and sick
- Historically had major issues recruiting and retaining physicians – lowest physician supply in the state
- Implemented a patient-centered medical home model to strengthen ability to recruit physicians as well as transform the delivery of care

## Key Requirements to Join Pilot

Required to achieve medical home recognition NCQA Level 2 or 3

Primary care practice with patient assigned a personal provider

Implement same day access with 24/7 telephone access for all patients

Adopt e-prescribing system by month 6 with benchmark of 80%

Implement evidence-based care with consistent approach to quality

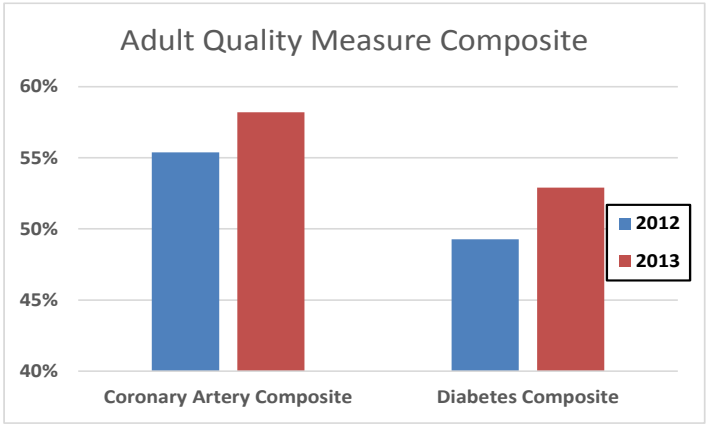
Create disease management with adult focus on diabetes, CAD and HTN, and pediatric focus on obesity, asthma and prevention

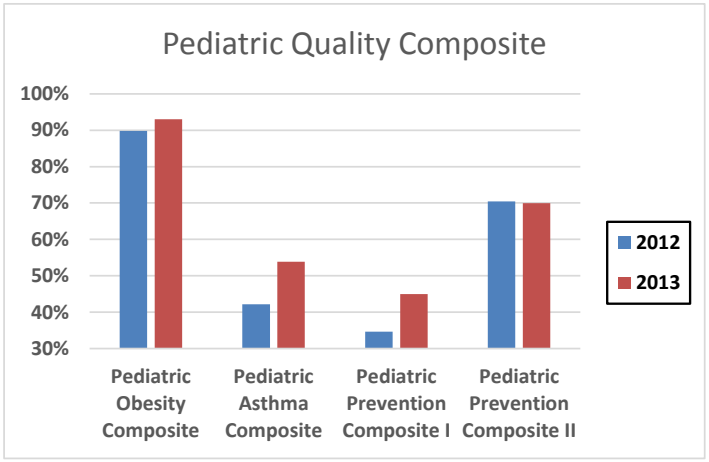
Coordinate care across continuum to include optimized transitions of care

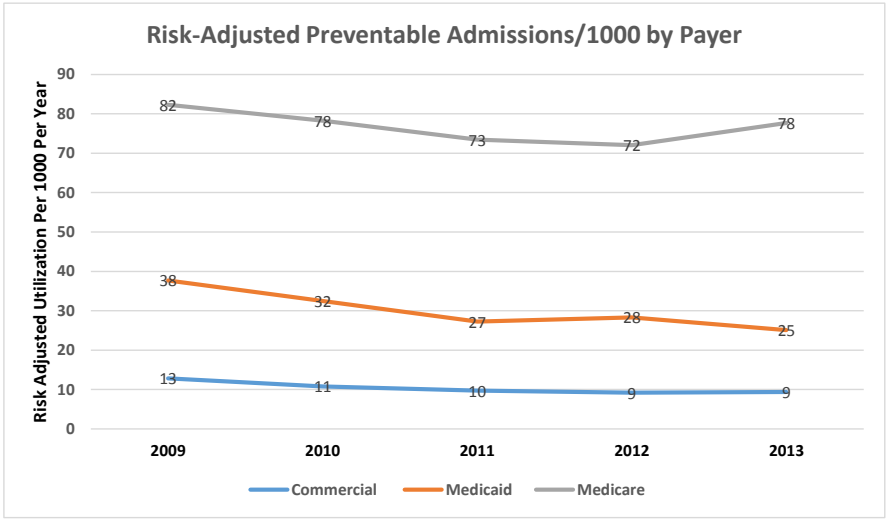
Join regional health information exchange that allows for data sharing that enhances patient care

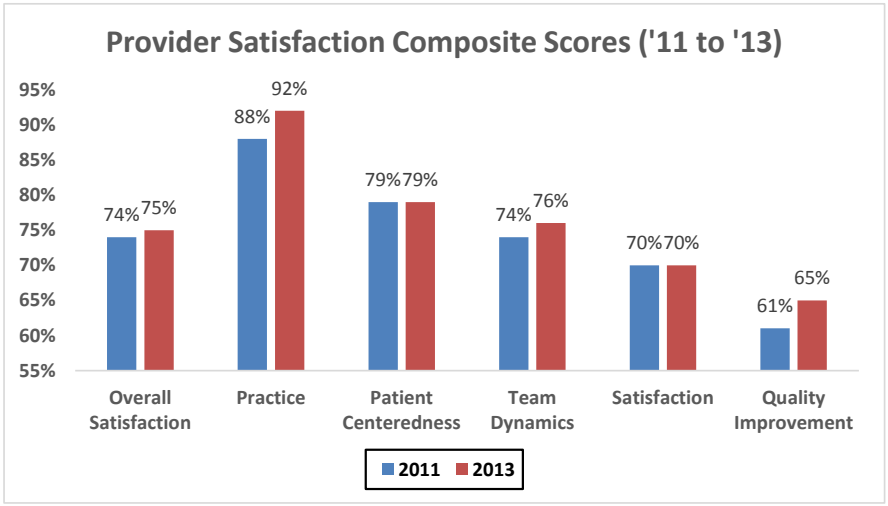
Participate in quality measurement and improvement activities to include reporting across provider groups

# Delivering Tangible Results – Benefitting all Stakeholders



# Components of an Effective Overall Program

## Necessary Infrastructure to Support New Models of Care

### Integrated Physician Organization

- Engage medical staff – both independent and employed
- Establish physician governance and leadership
- Develop new and ongoing program initiatives
- Create and administer value-based financial incentives

### Clinical Transformation Capabilities

- Medical Home
- Care Transitions
- Establish ambitious standards for delivery system redesign
- Focus on chronic disease and prevention
- Analytics to ensure high quality, low cost care
- Management infrastructure

### Robust Technology Platform

- Provide visibility across full care continuum
- Monitor performance across key metrics and initiatives
- Address physician concerns about data integrity
- Demonstrate value proposition to payer partners

### Effective (FFS) Payer Strategy

- Proactively solicit pay-for-performance incentives to augment fee-for-service payment
- Partner and negotiate with commercial payers on behalf of full physician network

# Collaborating to Deliver More Services Virtually

## Services Can be Offered at a Lower Cost


**Remote**

- Diagnoses, treatments follow reliable standard protocols based on evidence-based medicine
- Suggested therapies are nearly always effective
- Physical exam not required, visual exam adds nominal value

**Emerging Areas for Virtual Care**

***Management, Maintenance***

- Chronic disease checkups, follow-ups
- Care plan updates
- Specialist consults

***Diagnosis, Treatment***

- Remote diagnostics
- Self-guided interventions

**In-Person**

- Diagnoses, treatments more complex, may vary within disease category
- Therapies may need careful selection and monitoring
- Physical exam or diagnostic test required to correctly identify issue and select treatment
- Intervention required (i.e., immunization)



Source: Marketing and Planning Leadership Council interviews and analysis.

# Moving Forward with Telehealth Services

## Telehealth Pilot Shows Early Adopters Now Recruiting Early Majority

**92%** Of a virtual visit provider's patients said they would use the service again

**91%** Of Zipnosis users would recommend the service to at least three friends

**71%** Of midsized to large U.S. employers anticipate offering employees telehealth services within three years

### Case in Brief: Medical Associates Clinic

- Four-physician practice in Kentucky
- Piloted the Me-Visit mobile app to offer online care for primary care and chronic condition follow up needs
- In 30-month pilot, 20% of patients used the app, and 97% of users preferred the service to in-person care

Source: 2014 Primary Care Consumer Choice Survey; Teledoc, available at http://www.teladoc.com/healthplans/how-it-works-for-your-members/, accessed July 2014; "The Virtual Primary Healthcare Revolution," Becker's Hospital Review, available at http://www.beckershospitalreview.com/strategic-planning/the-virtual-primary-healthcare-revolution-what-health-systems-need-to-know.html, accessed July 2014; "Just how far in usage and savings can telemedicine take US healthcare?" mHealthNews, available at http://www.mhealthnews.com/news/just-how-far-usage-and-savings-can-telemedicine-take-us-healthcare, accessed August 2014; Marketing and Planning Leadership Council interviews and analysis.

# Me-Visit Mobile App Outcomes

## KY-Based Medical Associates Clinic Realized Significant Benefits

### Patient Education and Population Health

- Served patients in 9 rural counties, 5 of which are classified as impoverished and medically underserved
- Utilized both English and Spanish features

### Patient Satisfaction

- 97% patient satisfaction rate
- 100% of surveyed patients reported that they would used the service again

### Practice Management

- Formerly lost revenue from care provided over the phone can now be captured which lowers liability risk
- Clinic capacity increased and lead time for in-office visits decreased

### Patient Safety and Quality

- Zero adverse quality or safety outcomes
- Very high quality and safety ratings

### Clinic Personnel

- No IT support or significant change in workflow required
- No disruption in clinicians' quality of life

### Provider Productivity

- Clinicians provided virtual care in an average of less than 3 minutes per case during clinic between patients

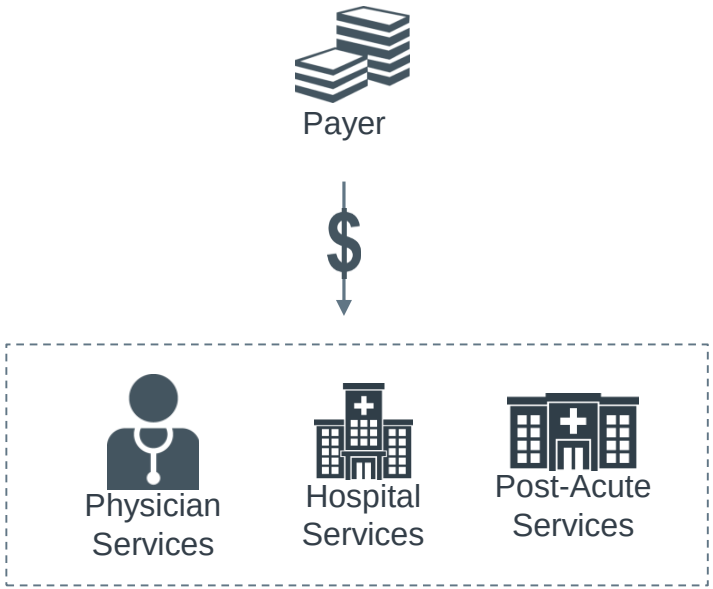
Source: Thornbury, Steven C. "A Multi-Specialty Primary Care Medical CIlinicCase Study: Me-Visit Technologies" https://www.mevisit.com/mevisit/resources/MeVisit_CaseStudies.pdf

# Redefining the Acute Care Episode

Bundled Payments Drive Delivery System Integration

## Bundled Payment Framework

*Lump Sum Payments Drive Integration Through Shared Accountability*




## Program in Brief: Medicare's Bundled Payments for Care Improvement

- CMMI[1] initiative offering four voluntary bundled payment models; more than 450 providers selected to participate
- Models 1-3 provide retrospective reimbursement; Models 2 and 3 include post-episode reconciliation; Model 4 offers single prospective payment
- Acute care hospitals, physician groups, health systems eligible for all models; post-acute facilities may participate without hospitals in Model 3
- Physicians eligible for gainsharing bonuses up to 50 percent of traditional fee schedule
- For all models, applicants must propose quality measures, which CMS will use to develop set of standardized metrics

1) Center for Medicare and Medicaid Innovation.

Source: Centers for Medicare and Medicaid Services; Health Care Advisory Board interviews and analysis.

# Defining and Contracting for Episodes of Care

The Tennessee Definition

Patients seek care and select providers as they do today

Providers submit claims as they do today

Payers reimburse for all services as they do today

"Quarterbacks" are provided detailed information for each episode which includes actionable data

Also receive quarterly reports showing underlying costs and quality indicators for their episodes

- Quality thresholds achieved with scores and comparison to other providers and gain share standard
- Key utilization statistics
- Total number of episodes
- Cost comparison to other providers and gain and risk sharing thresholds

"Quarterbacks" are financially rewarded for high quality and efficient care. They share in the savings they create, or in any excess cost they incur

- Acute Asthma Exacerbation
- Perinatal
- Total Joint Replacement (Hip and Knee)
- Acute COPD Exacerbation
- Screening and surveillance colonoscopy
- Acute PCI
- Non-acute PCI

# Mechanics of the MSSP Model

## Applying Total Cost Accountability to Fee-for-Service Payments

### Program in Brief: Medicare Shared Savings Program

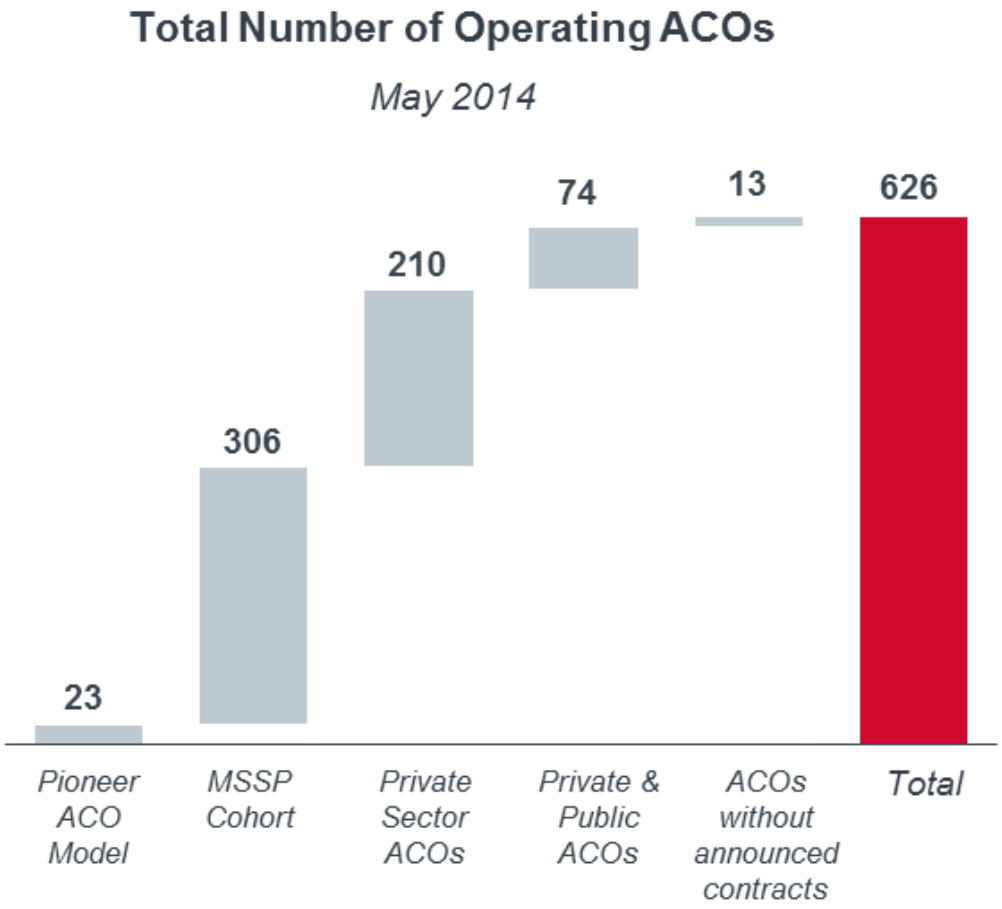
- Cohorts launched April 2012, July 2012, and January 2013; contracts to last minimum of three years
- Physician groups and hospitals eligible to participate, but primary care physicians must be included in any ACO group
- Participating ACOs must serve at least 5,000 Medicare beneficiaries
- Bonus potential depends on Medicare cost savings, quality metrics
- Two payment models available: one with no downside risk, the second with downside risk in all three years

### Shared Savings Payment Cycle

1. **Assignment**
   Patients assigned to ACO based on terms of contract
2. **Billing**
   Providers bill normally, receive standard fee-for-service payments
3. **Comparison**
   Total cost of care for assigned population compared to risk-adjusted target expenditures
4. **Shared Savings Payment**
   Bonuses or penalties levied based on variance of expenditures from target
5. **Distribution**
   ACO responsible for dividing bonus payments among stakeholders

Source: Health Care Advisory Board interviews and analysis.

# Adopting and Adapting the MSSP for Local Use




## Widening Reach of ACOs[1]

**67%** Portion of U.S. population living in a primary care service area with an ACO

**17%** Portion of U.S. population treated by an ACO

**5.3M** Medicare FFS beneficiaries treated by an ACO

1) As of April 2014.

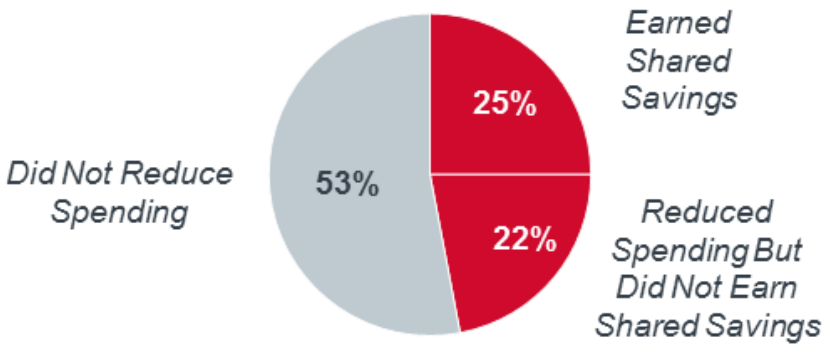
Source: Oliver Wyman, "ACO Update: Accountable Care at a Tipping Point," April 2014; Leavitt Partners, "Growth and Dispersion of ACOs," June 2014; Marketing and Planning Leadership Council interviews and analysis.

# Physician Led Adopters Beginning to Move the Financial Dial

## Physician-Led ACOs More Likely to Generate Savings

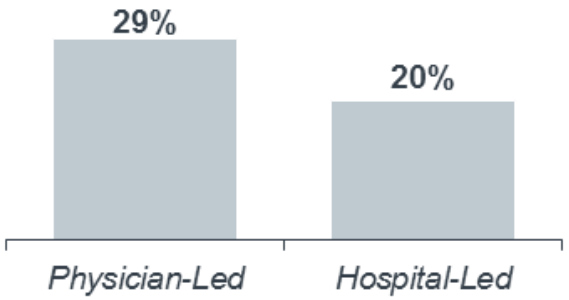
### First-Year Spending Reduction By MSSP[1] ACOs

*2012 Cohort*




### Percent of MSSP ACOs that Earned Shared Savings by Sponsorship

*2012 Cohort*




**$126M**
Shared savings earned by 2012 MSSP ACOs in first year

**$147M**
Total cost savings by Pioneer ACOs in first year

1) Medicare Shared Savings Program.

Source: Muhlestein D, "Accountable Care Growth in 2014: A Look Ahead," Health Affairs Blog, January 29, 2014, available at: www.healthaffairs.com/blog; CMS, "More Partnerships Between Doctors and Hospitals Strengthen Coordinated Care for Medicare Beneficiaries," December 23, 2013; Oliver Wyman, "Accountable Care Organizations Now Serve 14% of Americans," February 19, 2013; Health Care Advisory Board interviews and analysis.

# General Discussion

## Questions and Answers